



EXCLUSIVELY OFFERED THROUGH

Clements International®

1. Patient Information – 9 digit Identification Number Copy this from your Scholars Identification card**B**

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Patient's Name (Given Name, Family Name)	Patient's date of birth MM/DD/YYYY / /	Patient's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Name of Insured Member (Given Name, Family Name)	Insured's date of birth MM/DD/YYYY / /	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Employer of Insured Member:		
If Child is over 18 years of age, is he/she a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, what is the expected date of graduation _____		
School Name & Address:		
Insured's current mailing address:		

2. Other Health Insurance – Is the patient covered under other health insurance? ☐ Yes ☐ No If YES, please complete this section

Name and address of other insurance company:

Name of the Policy Holder:	Policy Holder's Date of Birth: MM/DD/YYYY / /	Policy or identification number of other coverage
Type of Policy <input type="checkbox"/> Family <input type="checkbox"/> Individual	Effective Date MM/DD/YYYY / /	Termination Date MM/DD/YYYY / /
Type of Coverage: Hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Illness: <input type="checkbox"/> Yes <input type="checkbox"/> No		

3. Diagnosis – describe illness, injury or symptoms requiring treatmentWas patient's treatment due to a work related accident or condition? ☐ Yes ☐ No
If yes, Employer's Name:**Complete for care related to accidental injuries**Date of accident _____ Location: ☐ At Home ☐ Auto ☐ Other: _____
Accident description* _____
*If the accident was caused by someone else, attach a statement describing the accident**4. Charges – use a separate line to list each type of service or provider and attach itemized bills for all services.**

Name, City & Country of provider making charge	Type of provider, hospital or pharmacy	Description of service	Dates of Service or purchase	Charges
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5. Payee – Select one of the following payment options:

- ☐ **Make payment to the provider (hospital, doctor). If paying provider, invoice must include bank information. Please complete and sign to authorize assignment of benefits.** I, the undersigned, authorize and request HTH Worldwide to make payment for benefits due herein to:

Name of Provider _____ Signature of Subscriber or Spouse _____ Date _____

- ☐ **Make payment to Primary Insured Member –** Please select your method for payment ☐ US Dollar Check ☐ Bank Wire Transfer (complete below)

Account Holder's Name – Insured Member must be a signer on the account:			
Bank Name:		Bank Address –	
Currency of Reimbursement:		City & Country of branch location :	
Bank 9 digit ABA Number – Mandatory for US Banks:		Bank 8 or 11 digit SWIFT Code – Mandatory for NON-US Banks:	
Bank Account Number:		Bank IBAN :	

6. Signature – I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, that participated in any way in the patient's care, to release to HTH Worldwide and its business associated in any country any medical or other personal information that they deem necessary to provide service or adjudicate this claim, recognizing applicable concerning personal information may differ among countries.

Signature of Insured member or patient _____ Date _____



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Instructions for completing this claim form

Complete the claim form in its entirety – please use black ink

- Please submit a separate claim form for each patient
- Complete sections 1 & 2, answering all the questions

Diagnosis and Charges Section

- Please be as descriptive as possible
- Submitted bills must be itemized – canceled check, cash register receipts and non-itemized “balance due” statements cannot be processed.
 - Each itemized bill must include: Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.)
 - Name of patient
 - Date(s) of service
 - Amount charged for each service
 - Total Charge
 - Diagnosis or reason for treatment
- Submitted bills for prescriptions should include the name of the drug, the quantity dispensed and the dosage.

Payee Section

- Payments are made to the Primary Participant/Insured Member on the plan. Normally this means the member with the “00” suffix after this ID number. Payments cannot be made directly to a dependent or to a third party (other than the medical provider).
- For payments made via wire transfer/ACH, the Primary Participant/Insured Member must be listed as an account holder on the bank account receiving funds.

SEND COMPLETE CLAIM FORMS, WRITTEN INQUIRIES AND ADDRESS CHANGES TO ADDRESS BELOW

POWERED BY:

HTH Worldwide

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